DISCUSSION
These results highlight the challenges of even basic cognitive assessment in a carehome setting. Routine assessment of all carehome residents using recommended tools may not be feasible, and even a short test battery is associated with substantial noncompliance and administration time.

The three recommended assessments have differing purposes and do not necessarily have to be administered in sequence. The added test burden of performing all three assessments in a single session may have biased results particularly for the MoCA, which was always performed last. Accepting this caveat, the data would suggest that the AMT is a reasonable first screening assessment. The low completion rate and high prevalence of cognitive impairment at usual thresholds suggests that MoCA may not be suited to carehome settings.

The measures of test suitability, acceptance, and completion suggest problems of feasibility of a universal cognitive screening approach. Suitability for assessment was not operationalized but rather was left to the discretion of the senior unit staff. It was felt that this approach mirrored real-world settings. Although NHS-CC is a UK-specific resource, the case mix will be similar to higher-level nursing homes and long-term care facilities, and so the findings have external validity.

CONCLUSION
Time required and limited completion rates suggest that cognitive screening should be performed using the shortest validated tool. With the high prevalence of cognitive impairment in NHS-CC residents (at usual test thresholds), it could be argued whether screening for cognitive impairment per se is worthwhile. Targeted assessment for common incident problems that may require intervention such as delirium may be a more useful approach to cognitive assessment in carehome settings.

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CASE REPORTS
SUPERFICIAL VEIN THROMBOSIS IN FRAIL ELDERLY ADULTS
To the Editor: A nursing home resident in his 80s presented to the emergency department with pain and swelling in his left leg. Past medical history included hypertension, epilepsy secondary to a previous subdural hematoma, severe vascular dementia with functional dependence, and behavioral disturbances.

Medical records reported administration of low-molecular-weight heparin (LMWH) at therapeutic doses for suspicion of upper limb superficial vein thrombosis (SVT) in the presence of mild swelling in left upper limb in the last 10 days. In the absence of vascular access, hypodermoclysis was started because of dehydration.

At admission, the man was bedridden and in poor general condition, highly dehydrated, alert, not oriented, and uncooperative. He had a painful swelling in his left groin with erythematous skin. His blood pressure was 110/70 mmHg, heart rate 90 (sinusal rhythm), temperature 37°C, oxygen saturation 97% (fraction of inspired oxygen 0.21). Laboratory tests showed severe leukocytosis (white blood cell count 34.30 × 10^9/L) with high inflammation indices (C-reactive protein 106.2 mg/L), thrombocytosis (platelets 877 × 10^9/L), and mild anemia (hemoglobin 10.2 g/dL, hematocrit 31.6%); hepatorenal function was normal.

Left lower limb ultrasound imaging showed no signs of vein thrombosis but a wide thigh abscessualized hematoma (Figure 1); a percutaneous drain was positioned. Despite intensive antibiotic treatment with ampicillin with sulbactam and vancomycin according to local infection control guidelines, he developed septic shock and general worsening of his condition and soon died.

Lower limb deep vein thrombosis (DVT) is a serious event, with high risk of pulmonary embolism. Although a
practice, but physicians should always keep in mind that most of these guidelines are based on studies that enrolled younger, healthier participants than those found in real-world clinical practice. Moreover, a careful analysis of the balance between benefit and harm should always be made for frail, vulnerable individuals, who are highly susceptible to serious adverse events.

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REFERENCES

PROGRESSIVE SUPRANUCLEAR PALSY—AN UNUSUAL CAUSE OF MEMORY LOSS AND FALLING

To the Editor: A woman in her 60s was referred to a memory disorders clinic with a 1-year history of memory loss. She also had multiple falls, mostly backward falls. Other problems included urinary incontinence, toe dystonia, depression, and behavioral abnormalities. She was originally diagnosed with atypical Parkinson’s disease (PD) and had some response to levodopa with carbidopa. Examination found fluent speech with decreased content and slow irregular prosody, mild vertical gaze deficit, ptosis, and forward head tilt when gazing down. Review of the clinical presentation and brain magnetic resonance